

ST. MARGARET'S SCHOOL
Tappahannock, Virginia 22560
Telephone (804) 443-3357

PART I: STUDENT HEALTH INFORMATION

State Law (Ref. Code of Virginia 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering school. The parent or guardian completes this page (Part I) of the form. The medical provider completes Part II and Part III State Required Immunizations.

Student's Name _____		Grade _____	
Student's Date of Birth ____/____/____		SS# _____	
Student's Address _____		City _____	State ____ Zip _____
Student resides with _____		Both _____	Mother _____
		Father _____	Guardian _____
Mother or Legal Guardian _____	Phone _____	Work or Cell _____	
Father or Legal Guardian _____	Phone _____	Work or Cell _____	
Emergency Contact _____	Phone _____	Work or Cell _____	

MEDICAL INSURANCE INFORMATION: (We will need a copy of the front and back of your insurance card. **Please attach it to this form.**)

Policyholder's Name _____	Date of Birth _____	SS# _____
Insurance Company Name _____	Policy# _____	Group# _____
Street Address _____	City _____	State ____ Zip _____

CONDITION	YES	COMMENTS	CONDITION	YES	COMMENTS
Allergies (food, insects, drugs, latex)			Diabetes (Type I or II)		
Allergies Seasonal			Head or spinal injury		
Asthma			Hearing/Vision problems		
Attention Deficit/Hyperactive Disorder			Heart problems		
Behavioral problems			Headaches/Migraines		
Developmental problems			Psychological problems		
Bladder problems			Seizures		
Bleeding problems			Sleep Walking		
Contact Lenses			Sickle Cell (not Trait)		
Eating Disorder			Sinus Problems		
Dental problems			DATE OF LAST TETANUS BOOSTER		

Describe any other important health-related information about your child:

List all prescription, over-the-counter, and herbal medications your child takes regularly: International Students MUST have ALL medications translated into English before bringing them to campus.

I give the Health Center staff permission to administer over-the-counter medication or prescription medication to my daughter as prescribed by a licensed physician.

Signature of Parent or Legal Guardian: _____

Date: _____

TREATMENT AUTHORIZATION:

I authorize the physician, school nurse, or other health professional to render necessary medical care to my child/ward named above. I understand that this authorization does not include medical care beyond that which is usual and customary for routine or emergency treatment. However, in the event of an emergency, and if I am unable to be reached by the school, hospital, nurse, or physician, as the case may be, I consent for St. Margaret's School to act on my behalf in granting permission for medical treatment, including surgery requiring the use of an anesthetic. This authorization shall be in effect as long as my child is a student at St. Margaret's School. I give permission to release medical information regarding my child to the faculty and /or administration at St. Margaret's School and other health care providers as necessary. This information will be released on a need-to-know basis and will be kept confidential by those persons.

Signature of Parent or Legal Guardian: _____

Date: _____

ST. MARGARET'S SCHOOL

PART II: COMPREHENSIVE PHYSICAL EXAM FORM

PHYSICAL EXAMINATION MUST BE COMPLETED BY A QUALIFIED LICENSED PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

STUDENT'S NAME _____		DATE OF ASSESSMENT: _____	
DATE OF BIRTH _____	SEX _____	WEIGHT _____ lbs.	HEIGHT _____ ft. _____ in.
BODY MASS INDEX (BMI): _____		BP _____	Pulse _____
		Urinalysis _____	Hemoglobin _____
PPD (REQUIRED YEARLY) Date given _____		Date Read _____	RESULTS: _____ MM _____
If positive, it will be necessary to document a normal chest x-ray or treatment or INH treatment.			
Date of REQUIRED Meningococcal Vaccine _____		Date of last Tetanus Booster _____	

Physical Exam

HEENT	Abdomen	Urinary
Lungs	Extremities	Neurological
Heart	Skin	Genital

Vision/Hearing

Eyes: R20/ _____ L20/ _____	Hearing: R+ _____ L+ _____	
Wears glasses _____	Hearing aid _____	
Contact lenses _____		

***Immunizations:** All students must show proof of immunization as mandated by Virginia State Law. IMMUNIZATION RECORDS must be obtained before school admission. **SMS also requires meningococcal vaccine (Menactra) to be administered and yearly PPD to be administered, regardless of prior BCG vaccination. Boarding students must have proof of immunization before entry to dormitories.**

Intervention

<p>Summary of findings: (Check one)</p> <p>_____ Well child: no condition identified of concern to school program activities.</p> <p>_____ Conditions identified that are important to schooling or physical activity.</p> <p>(Complete sections below and/or explain here):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____ Allergy: Food _____ Insect _____ Medication _____ Other _____</p> <p>Type of allergic reaction: Anaphylaxis _____ Local Reaction _____</p> <p>Response required: None _____ Epi-Pen _____ Other _____</p> <p>_____ Individualized Health Care Plan needed (e.g. Asthma, Diabetes, Seizure disorders, Severe Allergy, etc.)</p> <p>Medications: Please list medications child takes for specific health conditions:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Special Diet _____ or Special Needs _____</p> <p>Other comments: _____</p>
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I certify that I have on this date examined this student and find her physically able to compete in supervised activities such as: Baseball, Basketball, Crew, Cross Country, Field Hockey, Golf, Kayaking, Rock Climbing, Soccer, Skiing, Snow Boarding, Swimming, Tennis and Volleyball.

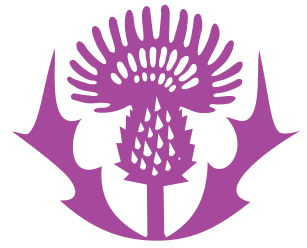
Health Care Professional's Certification (Write legibly or stamp):

Name: _____ Signature: _____ Date: ____/____/____

Practice/Clinic Name: _____ Address _____

Phone: _____ Fax: _____ E-Mail _____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM



Part **III** - Certification of Immunization

Section I

To be completed by a physician, registered nurse, or health department official.

(A copy of the immunization record signed or stamped by physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: |__| |__| |__|
Last First Middle Mo. Day Yr.

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Minimum requirements are listed in Section III).

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): ___/___/___

Student's Name: _____

Date of Birth: |__|_|_|_|_|

Section II
Conditional Enrollment and Exemptions

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap: [___]; DT/Td: [___]; OPV/IPV: [___]; Hib: [___]; Pneum: [___]; Measles: [___]; Rubella: [___]; Mumps: [___]; HBV: [___]; Varicella: [___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (Mo., Day, Yr.): |__|_|_|_|_|.

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): |__|_|_|_|_|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): |__|_|_|_|_|

Section III
Requirements

*Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)

- 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
 - Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
 - 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
 - Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
 - Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
 - 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
 - 1 Mumps – on/after 12 months of age
 - 1 Rubella - on/after 12 months of age
- Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
 - 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

* Additional Immunizations Required at Entry into 6th Grade

- Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>